EDGEWOOD

Early Childhood Mental Health Consultation

Consent for Consultation

Name of Child: _____

Date of Birth: _____

I give my permission for a consultant from Edgewood's Mental Health Consultation Program to observe and provide support for my child in his/her/their childcare center. I also give permission for the consultant and my child's teachers to exchange information about my child. I also understand that the consultant will work with the teachers in their efforts to understand and address my child's needs in the childcare program.

I understand that I am giving my consent for services voluntarily, and I may withdraw my consent to consultation services at any time by informing my child's consultant. My signature on this form indicates that I fully understand it and agree to its terms. This consent is valid for one (1) year unless withdrawn.

All consultation services are currently being provided by phone or video conference. If you have any questions regarding these services, please feel free to contact the director of your child's childcare center or the Edgewood Clinical Program Manager, Katherine Winship, 415-871-6921.

Name of Center: _____

Name of Classroom: _____

Name of Legal Guardian: _____

Relationship to Child: _____

Signature of Legal Guardian: _____

Phone Number: _____ Date: _____